MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117a)

09927

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: ~~unknown~~ 3009 St. Paul St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: David H. Anderson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 3/18/83

8. AGE: Years	Months	Days	If less than one day
62	6	9	..... hrs. ..... min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Railroad Work
11. Industry or business:
12. FATHER — Name: George Anderson
13. FATHER — Birthplace: Pennsylvania
14. MOTHER — Maiden name: Alice Kline
15. MOTHER — Birthplace: Pennsylvania
16. Informant: Records of Springfield Hospital
Address: Sykesville, Md.
17. Removals (Burial, cremation, or removal. Which?) Date thereof: Oct. 28, 1945 (month) (day) (year)
Cemetery or crematory:
Location: Camden, N. J.
18. Funeral director: C. Harry Weer
Address: Sykesville, Md.
19. Oct 28 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27 1945, at 7:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 14 1945, to October 27 1945, and that I last saw him alive on October 27 1945.

Immediate cause of death	DURATION
Hemorrhage	1 hour(?)
~~Coronary Thrombosis~~ ← a.h.e.	xxx
Due to: Peptic Ulcer	?
Due to:	
Other conditions: Undiagnosed lung lesion	15 days

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Peptic ulcer; fresh blood in stomach + small intestine
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. (M. D. or other)
Address: S.S. Hosp. Sykesville, Md. Date signed: 10-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09928

CERTIFICATE OF DEATH

★ Reg. Dist. No. 74

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 month, 2 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 712 N. Carrollton Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: IRENE BALL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Andrew Ball

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Oct., 30, 1900

8. AGE: Years	Months	Days	If less than one day
45	0	0	...hrs. ...min.

9. Birthplace: Lillian, Va (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: William Haynie
13. Birthplace: Virginia

MOTHER — 14. Maiden name: Martha Bell
15. Birthplace: Virginia

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 2-1945 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial P.K.
Location: Baltimore County Md.
16. Funeral director: Charles G. Cosden
Address: 512 N. Carrollton Ave

19. 10/30 (Date rec'd by registrar) 19 45 Albert A. Brandau Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30, 1945 at 1.45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28, 1945, to Oct., 30, 1945 and that I last saw her alive on October 30, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed 10/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09929

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL NEAR SYKESVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yr., 9 mo., 23 days

Hospital, Institution, or street address where death occurred:
SPRINGFIELD STATE HOSPITAL

How long in hospital or institution? 10 yr., 9 mo., 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: Howard

City or town: rural near Laurel
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Justin J. Barkman

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 1, 1887

8. AGE: Years	Months	Days	If less than one day
58	4	1	..... hrs. ..... min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: George W. Barkman
13. Birthplace: Baltimore City, Maryland

MOTHER
14. Maiden name: Mary A. Dousch
15. Birthplace: Baltimore City, Maryland

16. Informant: SPRINGFIELD STATE HOSPITAL RECORDS
Address: SYKESVILLE, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 3-45 (month) (day) (year)

Cemetery or crematory: Most Holy Redeemer

Location: Baltimore, Md

18. Funeral director: Lloyd Kaiser

Address: Laurel Md.

19. Oct 2 1945 (Date rec'd by registrar) Henry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 2 19 45 at 2:50a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 43 to October 2 19 45

and that I last saw him alive on October 1 19 45

Immediate cause of death	DURATION
(congenital) Cerebral palsey	58 yrs.
Due to	
Due to	
Other conditions: Mental deficiency, without psychosis	58 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

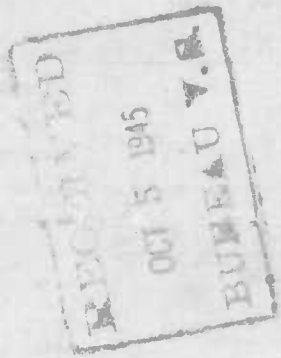
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

ROBERT BERTRAND MAY, M.D.

23. SIGNATURE: Robert Bertrand May M.D.
SPRINGFIELD STATE HOSPITAL M.D. or other
Address: SYKESVILLE, MARYLAND Date signed: 10-2-45


RECEIVED
OCT 15 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

09930 76

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 38 Penn. Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Grace Ellen Barnhart

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife George David Barnhart
6.(c) If alive, give age 68 years
7. Birth date of deceased (mo., day, yr.) Aug. 14 1879

8. AGE: Years	Months	Days	If less than one day
66	2	10	hrs. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name James Edward Lowe
13. Birthplace Md.

MOTHER
14. Maiden name Mary Ellen Brothers
15. Birthplace Md.

16. Informant David B. Barnhart
Address 38 Penn. Ave. Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-26-1945 (month) (day) (year)
Cemetery or crematory Leister cemetery
Location Westminster, Md.
18. Funeral director H. Bankard & Son
Address Westminster Md.
19. 10/26 1945 R. L. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1945 at 10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1945 to Oct 24, 1945
and that I last saw h[illegible] alive on Oct 13, 1945

	DURATION
Immediate cause of death Coronary occlusion	Probably a few minutes
Due to Hypertensive Cardio vascular disease	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. Reese Wilkins, M.D.
M. D. or other
Address Westminster Md Date signed 10/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09931

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 13 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 800 George Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HARRY NORMAN BIDDLE

3.(b) Social Security Number: 220-18-3489

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 14, 1927

8. AGE: Years	Months	Days	If less than one day
18	4	15	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Bakery Helper

11. Industry or business

FATHER
12. Name: Harry Biddle, Sr.
13. Birthplace: Baltimore, Md

MOTHER
14. Maiden name: Lenora Reid
15. Birthplace: Baltimore, Md.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-2-45 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Balto. Md.

18. Funeral director: Samuel W. Bryce & Son
Address: 638 N. Gilmor St. Balto.

19. 10/29 (Date rec'd by registrar) 19 45 Albert [illegible] Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 29, 1945, at 7.15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16, 1945, to Oct. 29, 1945 and that I last saw h im alive on October 29, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M. D. M. D. or other
Address: Henryton, Md. Date signed 10/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

09932

Reg. Dist. No. 7H

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL NEAR SYKESVILLE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 10 mo., 24 days

Hospital, institution, or street address where death occurred:

SPRINGFIELD STATE HOSPITAL

How long in hospital or institution? 1 yr., 10 mo., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: Baltimore

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Louis Blimline

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 7, 1876

8. AGE: Years	Months	Days	If less than one day
69	9	22	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: tinner

11. Industry or business

FATHER — 12. Name: Andrew Blimline

FATHER — 13. Birthplace:

MOTHER — 14. Maiden name: Ricky Rode

MOTHER — 15. Birthplace:

16. Informant: SPRINGFIELD STATE HOSPITAL RECORDS

Address: SYKESVILLE, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 31, 1945 (month) (day) (year)

Cemetery or crematory: Schwartz Cemetery

Location: Balto. City

18. Funeral director: Lilly & Zeiler, Inc.

Address: 403 S. Wolfe St.

19. Oct 29 1945 (Date rec'd by registrar) C. Henry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 29 19 45 at 7:05a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 5 19 44, to Oct. 29 19 45 and that I last saw him 1M alive on Oct 29 19 45

Immediate cause of death	DURATION
Arteriosclerosis	1 year
Due to:	
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

ROBERT BERTRAND MAY, M.D.

23. SIGNATURE: Robert Bertrand May M.D.

SPRINGFIELD STATE HOSPITAL M. D. or other

Address: SYKESVILLE, MARYLAND Date signed: 10-29-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Items 6b, 7 and 8: Film G-10-24-45-L (Doctor Baer's records)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-A)

09933

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Md. (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs., 7 mos., 22 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 7 yrs., 7 mos., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2107 Penrose Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: Samuel Bontempo

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband~~ wife: ~~Unknown~~ Teresa Di Stefano

6.(c) If alive, give age ~~Unk~~ 40 years

7. Birth date of deceased (mo., day, yr.): JUNE 11 1899 ~~Exact date unknown~~

8. AGE: Years 46 ~~45~~ | Months ~~Unk.~~ 4 | Days ~~Unk.~~ 5 | If less than one day ..... hrs. ..... min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual occupation: Mechanic's Helper

11. Industry or business:

FATHER
12. Name: Joe Bontampo
13. Birthplace: Italy

MOTHER
14. Maiden name: Sabilla Deschindo
15. Birthplace: Italy

16. Informant: Springfield Hospital Record
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 19 1945 (month) (day) (year)

Cemetery or crematory: Holy Redeemer Cem.

Location: Balto. Md.

18. Funeral director: Joseph Fazzi, Inc.

Address: 2013 Fremont Ave.

19. Oct. 16 1945 (Date rec'd by registrar) C. Haugsveen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16 1945 at 12:30 M a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 23, 1938, to October 16 1945 and that I last saw him alive on October 15 1945

Immediate cause of death	DURATION
General paralysis of the insane--prior to 2-23-38	
Due to: syphillis	
Due to:	
Other conditions: Psychosis with syphilitic meningo-encephalitis-prior to 2-23-38 (Include pregnancy within 3 months of death)	

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M.D. M. D. or other

Address: Sykesville, Md. Date signed: 10-16-45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

09934

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs. 2 mths. 12 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 14 yrs. 2 mths. 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Frederick
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Addie Bowers

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years	Months	Days	If less than one day
76	unknown		..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: James Weddle
13. Birthplace: Maryland

MOTHER
14. Maiden name: Jane R. Engle
15. Birthplace: Maryland

16. Informant: Hospital Record
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-20-45 (month) (day) (year)

Cemetery or ~~crematory~~: Mt. Olivet Cemetery

Location: Frederick - Md.

18. Funeral director: C. E. Cline and Son

Address: Frederick - Md.

19. Oct. 18 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18th 1945, at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from July 1st 1941, to October 18 1945
and that I last saw her alive on October 17th 1945

Immediate cause of death	DURATION
Arteriosclerosis	10 years
Due to: Inactive pulmonary tuberculosis	6 years
Due to:	
Other conditions: Dementia Praecox	14 years

(Include pregnency within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Irene Hilleman, M.D.
M. D. or other

Address: Springfield State Hosp. Date signed: 10-18-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09935

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years, 4 months, 11 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 8 years, 4 months, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2322 East Federal Street

(If rural, give LOCATION)

2.(a) If veteran, name war: N

3.(a) FULL NAME: Mollie Bristow

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 20, 1863

8. AGE: Years	Months	Days	If less than one day
82	1	7	hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: William Thomas Tracy

13. Birthplace: Washington, D.C.

MOTHER

14. Maiden name: Virginia Candee

15. Birthplace: Washington, D.C.

18. Informant: Hospital record

Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 30, 1945 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Woodlawn, Balto. Co. Md.

18. Funeral director: Leo L. Cook

Address: 1703 N. Patterson Park ave.

19. Oct 27 1945 (Date rec'd by registrar) C. Henry Edel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27 1945, at 2.10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 1942 to October 27 1945 and that I last saw her alive on October 26 1945

Immediate cause of death	DURATION
Chronic myocarditis	7 years
Due to:	
Due to:	
Other conditions: senile psychosis	9 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Irene Hilchman, M.D. M. D. or other

Address: Springfield State Hosp. Date signed: 10-27-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

09936 Reg. Dist. No. 77

1. PLACE OF DEATH:
County: Carroll
City or town: Greenmount Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED.
(For newborn infants give residence of mother)
State Oct. 31, 1945 County Carroll
City or town Greenmount Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John H Brodbeck

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband Annie M Bradbeck 6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) March 14, 1877

8. AGE: Years 68 | Months 7 | Days 17 | If less than one day ..... hrs. ..... min.

9. Birthplace Penna (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name John W Bradbeck
13. Birthplace Penna

MOTHER 14. Maiden name Alice Mayelock
15. Birthplace Maryland

16. Informant Annie M Bradbeck
Address Greenmount Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-4-45 (month) (day) (year)
Cemetery or crematory Cemetery
Location Greenmount Md

18. Funeral director Earl Winks Sons
Address Manchester Md

19 Nov 2 19 45 (Date rec'd by registrar) John S. Hughes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 19 45 at 4: p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 45 to Oct. 31 19 45 and that I last saw h alive on Oct. 31 19 45

	DURATION
Immediate cause of death Coronary Thrombosis	20 min.
Due to Coronary Arteriosclerosis	2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the followlog:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE. M. C. Cartwright M. D. or other
Address Hampstead, Md Date signed 11-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09937

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr, 11 mo's.

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Frederick

(If ontside city or town limits, write RURAL and give nearest town)

Street No. 175 W. All Saints Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: ANGUS BROWN

3. (b) Social Security Number: 217-18-7455

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): September 21, 1921

8. AGE: Years	Months	Days	If less than one day
24	1	5	hrs. min.

9. Birthplace: Frederick, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: John Brown

FATHER — 13. Birthplace: Mantoe, Va.

MOTHER — 14. Maiden name: Ida Sherren.

MOTHER — 15. Birthplace: Hyattsville, Md.

16. Informant: Reuben Hoffman, M. D.

Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 29, 1945 (month) (day) (year)

Cemetery or crematory: Cemetery Fairview

Location: Fairview - Frd. md

18. Funeral director: Harry E. Cady Co.

Address: Frederick, Md.

19. 10/26/ (Date rec'd by registrar) 19 45 Albert R. Goodman Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26, 19 45, at 10.45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 26, 43 to Oct., 26, 45

and that I last saw him alive on October 26, 19 45

Immediate cause of death: Pulmonary Tuberculosis — DURATION: May 1943

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Address: Henryton, Md. Date signed: 10/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09938

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 3 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 348, 23½ Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JAMES CHERRY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 3, 1944

8. AGE: Years	Months	Days	If less than one day
1	5	13	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: James Newton
13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Bertina Cherry
15. Birthplace: Baltimore, Md.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 20 1945 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cem.
Location: Annapolis County, Md.

18. Funeral director: Rayner Saddler
Address: 1412 E. Fenton Street

19. 10/16 (Date rec'd by registrar) 19 45 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16, 1945, at 10.10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13, 1945, to Oct., 16, 1945 and that I last saw h~~im~~ alive on October 16, 1945

Immediate cause of death	DURATION
Tuberculous Meningitis	Oct. 9, 1945
Due to: Primary Tuberculosis	March 1945
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. (M. D. or other)
Address: Henryton, Md. Date signed 10/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09939

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1130 Druid Hill Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: CATHERINE MILDRED CHILDS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 9, 1929

8. AGE: Years	Months	Days	If less than one day
16	2	14	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Student
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Madeline Childs.
15. Birthplace: Caroline County, Virginia

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Shipped (Burial, cremation, or removal. Which?) Date thereof: Oct 26-1945 (month) (day) (year)
Cemetery or crematory: Woodfad, Va
Location: Virginia
18. Funeral director: V. A. Brooks Runyard
Address: 1463 N. Carey St

19. Oct. 23, 19 45 (Date rec'd by registrar) Albert R. Swadkamp Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23, 19 45, at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1, 19 45 to Oct. 23, 19 45 and that I last saw h er alive on Oct. 23, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 10-23-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09940

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mo. 7 da.

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 4 mo. 7 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland ~~County~~ 1214 Ensor Street

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1214 Ensor Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Hazel Clancy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James E. Clancy

6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): June 27, 1904

8. AGE: Years	Months	Days	If less than one day
41	3	29	...hrs. ...min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Daniel Morrison
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Driscoll
15. Birthplace: Maryland

16. Informant: See Springfield State Hospital records.
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 29, 1945 (month) (day) (year)
Cemetery or crematory: New Cathedral Cemetery
Location: 4300 Old Frederick Rd.

18. Funeral director: Elmer H. Conklin & Son
Address: 924 E Eager St. Balto 2 Md.

19. Oct. 26 1945 C. Henry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26, 1945 19... at 7:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 19 45, to Oct. 26 19 45
and that I last saw h[illegible] alive on Oct. 26 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 yr. ?
Due to	
Due to	
Other conditions: Carcinoma of Sigmoid	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ...Injured at work?

23. SIGNATURE: Arnold H. Eckert, M.D.
M. D. or other

Address: S.H. Hosp., Sykesville, Md. Date signed: 10-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

09941

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL NEAR SYKESVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yr., 7 mo., 20 days

Hospital, institution, or street address where death occurred:
SPRINGFIELD STATE HOSPITAL

How long in hospital or institution? 23 yr., 7 mo., 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Patrick Clancy

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown 1879

8. AGE: Years	Months	Days	If less than one day
about 66			hrs. min.

9. Birthplace: Ireland
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business:

FATHER 12. Name: James Clancy

13. Birthplace: Ireland

MOTHER 14. Maiden name: Ann Harney

15. Birthplace: Ireland

18. Informant: SPRINGFIELD STATE HOSPITAL RECORDS

Address: SYKESVILLE, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 2, 1945 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry Wenz

Address: Sykesville, Md.

19. Nov. 2 1945 (Date rec'd by registrar) C. Harry Wenz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31 1945, at 11:47 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1 1943, to Oct. 31 1945 and that I last saw h[illegible] alive on October 31 1945

Immediate cause of death	DURATION
Chronic myocarditis & myocardial degeneration	10 yrs.
Due to:	
Due to:	
Other conditions: Dementia precox, paranoid type	25 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

ROBERT BERTRAND MAY, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.

SPRINGFIELD STATE HOSPITAL M.D. or other

Address: SYKESVILLE, MARYLAND Date signed 11/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

09942

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months, 6 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 11 months, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No. 113 E Church Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Catherine Cole

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 10, 1869

8. AGE: Years	Months	Days	If less than one day
76	3	22	hrs. min.

9. Birthplace: New York City (Town, county, and state)
10. Usual occupation: practical nurse
11. Industry or business:
FATHER 12. Name: unknown
13. Birthplace: unknown
MOTHER 14. Maiden name: unknown
15. Birthplace: unknown
16. Informant: Hospital record
Address: Springfield State Hospital
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 5 1945 (month) (day) (year)
Cemetery or crematory: St. John's Cemetery
Location: Frederick, Md.
18. Funeral director: M. R. Etchison & Son
Address: Frederick, Md.
19. Oct. 3 1945 C. Henry Ebert Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 2 1945 at 6.22 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 17 1945 to October 2 1945 and that I last saw her alive on October 2 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 hour
Due to: arteriosclerosis	20 years
Due to:	
Other conditions: Senile psychosis, agitated type	1 year

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irene Hitchcock, M.D.
M. D. or other
Address: Springfield State Hosp. Date signed: 10-3-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-L)

09943

CERTIFICATE OF DEATH

Reg. Diat. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 yrs 10 mo 14 da

Hospital, institution, or street address (where death occurred): Springfield State Hospital

How long in hospital or institution? 19 yrs 10 mo 14 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegheny

City or town: Eckhart Mines Md (If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Edward Condry

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Single

6.(b) Name of husband or wife:

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 1st 1901

8. AGE:

Years	Months	Days	If less than one day
44		21	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Not any

11. Industry or business:

FATHER 12. Name: William Condry

13. Birthplace: Maryland

MOTHER 14. Maiden name: Sallie Shrashberger

15. Birthplace: Jamonant Md

16. Informant: Mrs. Sallie Condry

Address: Eckhart Mines Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 25 1945 (month) (day) (year)

Cemetery or crematory: Frostburg

Location: Frostburg, Md.

18. Funeral director: Jacob Yoder

Address: Frostburg, Md

19. Oct 22 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 22 1945 at 2-45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 8 1926 to Oct 22 1945 and that I last saw h[illegible] alive on Oct 22 1945

Immediate cause of death	DURATION
Coronary Thrombosis	8 hrs
Due to: Ch. Myocarditis	10 yrs
Due to: Epilepsy	34 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. J. Martin M.D. M. D. or other

Address: Sykesville Md Date signed: 10/22/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

09944

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 11 mos 15 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 1 yr 11 mos 15 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Ida Crawford.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1867

8. AGE: Years 78 | Months — | Days — | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: housework

11. Industry or business:

FATHER 12. Name: James E. Crawford

13. Birthplace: Md.

MOTHER 14. Maiden name: Eliza Ann Davis

15. Birthplace: Md

16. Informant: Mrs B Crawford

Address: 617 Park Road NW Wash. DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 22, 1945 (month) (day) (year)

Cemetery or crematory: Rock Creek Cem.

Location: Washington D. C.

18. Funeral director: Deal Funeral Home

Address: 4812 Ga. Ave. N.W. Wash. D.C.

19. Oct 19 1945 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 15 1945, at 6:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 3. d 1943 to Oct 15 1945 and that I last saw h.. alive on Oct 15 1945

	DURATION
Immediate cause of death: Subdural hemorrhage	1 day
Due to: arteriosclerosis	
adenocarcinoma of stomach	?
Due to: with metastases to liver	?
and diaphragm	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. H. Martin M.D. M. D. or other

Address: Sykesville Md. Date signed: 10-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (468)

CERTIFICATE OF DEATH

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown, (If outside city of town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Taneytown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Annie Davidson

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): December 17, 1872

8. AGE: Years	Months	Days	If less than one day
72	10	11	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER 12. Name: John E. Davidson

13. Birthplace: Md.

MOTHER 14. Maiden name: Virginia A. Hahn

15. Birthplace: Md.

16. Informant: Dr. C.M. Benner

Address: Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/30/45 (month) (day) (year)

Cemetery or crematory: Lutheran Cemetery

Location: Taneytown, Md.

18. Funeral director: C.O. Fuss & Son

Address: Taneytown, Md.

19. Oct 29 1945 (Date rec'd by registrar) Ethel M. Meking Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 28th 1945 at 9 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20th 1945 to Oct 28th 1945 and that I last saw her alive on Oct 27th 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	8 days
Due to: Arterio Sclerosis	2 yrs.
Due to:	
Other conditions: Carcinoma of Rectum	6 mo

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. M. Benner M.D. M. D. or other

Address: Taneytown Md Date signed 10/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09946

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 9 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1735 Orleans St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: FRANK ARTHUR DENNIS

3. (b) Social Security Number: 223-14-3006

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Evelyn Dennis
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 5, 1913

8. AGE:	Years	Months	Days	If less than one day
	32	9	3	hrs. min.

9. Birthplace: Blackstone, Va.
(Town, county, and state)
10. Usual occupation: Welder
11. Industry or business: Unknown

FATHER
12. Name: Frank Dennis
13. Birthplace: Blackstone, Va.

MOTHER
14. Maiden name: Lillian Jones
15. Birthplace: Blackstone, Va.

18. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof 10/11/45. (month) (day) (year)
Cemetery or crematory:
Location: Blackstone Virginia
18. Funeral director: Walker Halstead.
Address: 9/18 Druid Hill ave.

19. 10/8 (Date rec'd by registrar) 19 45 Albert R. Swanston Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8, 19 45 at 8.25A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 29, 19 45 to Oct., 8, 19 45 and that I last saw him alive on October 8, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Mar., 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other
Address: Henryton, Md. Date signed: 10/8/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 09948

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Clifton Grant Wentzel Wilbiss

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Florence B. Wentzel Wilbiss

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 20 - 1869

8. AGE:

Years	Months	Days	If less than one day
76	1	23	hrs. min.

9. Birthplace: Frederick County Md (Town, county, and state)

10. Usual occupation: Feed Business

11. Industry or business: Grocery

FATHER

12. Name: George W. Wentzel Wilbiss

13. Birthplace: Maryland

MOTHER

14. Maiden name: Kate Baile

15. Birthplace: Maryland

16. Informant: Mrs Florence B Wentzel Wilbiss

Address: New Windsor, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 16-1945 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cemetery

Location: Uniontown Road

18. Funeral director: H. H. Hartzler & Sons

Address: Union Bridge & New Windsor Md.

19. Oct 15 1945 (Date rec'd by registrar) Evan S Bindert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 13 1945, at 7:45 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 7 1945 to Oct 13 1945 and that I last saw h.. alive on Oct 13 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. N. Fogg M. D. or other

Address: Union Bridge Date signed 10-18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64a)

CERTIFICATE OF DEATH

69948

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 10 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 month, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8 Walker Road, Baltimore, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Alice Grace Donovan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James Donovan
6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): June 18, 1907

8. AGE: Years	Months	Days	If less than one day
38	4	5	....hrs. ....min.

9. Birthplace: Massachusetts (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: ----

FATHER
12. Name: Charles E. O'Neill
13. Birthplace: Massachusetts

MOTHER
14. Maiden name: Grace A. O'Neill
15. Birthplace: Massachusetts

16. Informant: Records of Springfield State
Address: Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 27-45 (month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: German Hill Road
18. Funeral director: John G. Connelly
Address: 418 Eastern Ave. Engr.

19. Oct 27 1945 John G. Connelly Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22 1945 at 2:30 P M (After)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....
and that I last saw h.... alive on .... 19....

	DURATION
Immediate cause of death: Suffocation	
Due to: Hanging by the neck	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: Oct 22-45
Where did injury occur? Sykesville (City or town) Carroll (County) Md. (State)
Injured at home, farm, industry, public place (where?) Spring Field State Hospital
Means of injury: Hanging Injured at work? No

23. SIGNATURE: James F. Marsh Deputy Medical Examiner M. D. or other
Address: Westminster Md. Date signed: 10/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

09949

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL NEAR SYKESVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 11 mo., 26 days

Hospital, Institution, or street address where death occurred:
SPRINGFIELD STATE HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: Montgomery

City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1 West Everett St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Barkley Ferguson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	widowed

6.(b) Name of husband or wife: Lillie Hurrman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 22, 1861

8. AGE: Years	Months	Days	If less than one day
84	8	12	..... hrs. ..... min.

9. Birthplace: Charleston, Indiana
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Department store (carpets)

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: SPRINGFIELD STATE HOSPITAL RECORDS
Address: SYKESVILLE, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/6/45 (month) (day) (year)

Cemetery or crematory: Glenwood

Location: Washington, D. C.

18. Funeral director: Dawe & Pumphrey

Address: 8434 Ga. Ave. Silver Spring.

19. 10-4 1945 (Date rec'd by registrar) C. Harry Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4, 1945 at 9:08a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 19 1944 to October 4 1945 and that I last saw h IM alive on October 4 1945

Immediate cause of death	DURATION
Arteriosclerosis, prior to	1943
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

ROBERT BERTRAND MAY, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
SPRINGFIELD STATE HOSPITAL M. D. or other
Address: SYKESVILLE, MARYLAND Date signed 1-4-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09950

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 14 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1610 Presbury St.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ESTELLE ALLEN FULLER

3.(b) Social Security Number: 212-22-7274

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Married

6.(b) Name of husband or wife: Robert Fuller
6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): June 25, 1920

8. AGE: Years	Months	Days	If less than one day
25	3	19	hrs. min.

9. Birthplace: Franklin, N. C.
(Town, county, and state)

10. Usual occupation: Defense Worker

11. Industry or business:

FATHER
12. Name: John Green
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Hattie Burrel
15. Birthplace: North Carolina

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct. 17-45 (month) (day) (year)
Cemetery or crematory: Franklin N. C.
Location:
18. Funeral director: Geo. G. Kelsey
Address: 303 Freeman St.

19. 10/14 (Date rec'd by registrar) 19 45 Albert Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14, 19 45 at 7.00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30, 19 45, to Oct., 14, 19 45 and that I last saw her alive on October 14, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1944
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please nuderline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external caueee, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Meane of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 10/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

09951

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH:
County: Carroll
City or town: near Taylorsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: near Taylorsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. Westminster
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: THOMAS B. GARTRELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Edith M. Gartrell
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): May 20, 1885

8. AGE: Years: 60 | Months: 6 | Days: 5 | If less than one day: hrs. min.

9. Birthplace: ~~Farmer~~ Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER
12. Name: Aaron Gartrell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth Gosnell
15. Birthplace: Maryland

16. Informant: Mrs. Edith M. Gartrell
Address: Westminster, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 10-28-45 (month) (day) (year)
Cemetery ~~or crematory~~: Morgan Chapel
Location: Day, Carroll Co. Maryland

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. 10-27-1945 (Date rec'd by registrar) E. M. Farver Registrar
Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 25th 1945 at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 26 1945 to October 25 1945 and that I last saw h... living on October 25 1945

Immediate cause of death	DURATION
Pneumonia of Pneu-	3 days.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Preston Boon (M.D.)
M. D. or other
Address: Westminster Md. Date signed 10/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09952

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 408 N. Bruce
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ALICE GORDON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 23, 1875

8. AGE: Years	Months	Days	If less than one day
70	7	1	hrs. min.

9. Birthplace: Leonardtown, Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business:

FATHER
12. Name: James Barnes
13. Birthplace: St. Mary's County, Md.

MOTHER
14. Maiden name: Lottie Watts
15. Birthplace: St. Mary's County, Md.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof November 1, 1945 (month) (day) (year)
Cemetery or ~~crematory~~: Mt. Auburn
Location: Baltimore, Maryland
18. Funeral director: Mrs. Katie L. Williams
Address: 322 N. Schroeder St.

19. 10/28 (Date rec'd by registrar) 19 45 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28, 1945, at 1.00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 24, 1945, to Oct., 28, 1945 and that I last saw her alive on October 28, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

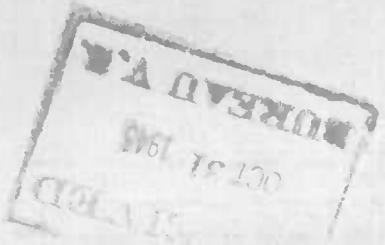
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 10/28/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


BUREAU V.A.
OCT 31 1946
RECEIVED

09953

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 82

1. PLACE OF DEATH:
County: Carroll
City or town: Mt. Olive, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Mt. Olive
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. Mt. Airy
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: HARRY H. GOSNELL

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Lillian L. Gosnell

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Aug. 10, 1874

8. AGE:

Years	Months	Days	If less than one day
71	2	9	....hrs. ....min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER
12. Name: Joseph Gosnell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Amelia Fleming
15. Birthplace: Maryland

16. Informant: Mr. Joseph H. Gosnell
Address: Mt. Airy. Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-21-45 (month) (day) (year)
Cemetery ~~or crematory~~: Mt. Olive
Location: Mt.Olive, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. Oct 19 1945 (Date rec'd by registrar) Thos D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 19, 1945 at 4:30A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1943 to Oct 19. 1945 and that I last saw him alive on Oct 18 1945

Immediate cause of death	DURATION
Coronary Arterio-Sclerosis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J Stanley Grabill M. D. or other
Address: Mt Airy, Md. Date signed 10/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
OCT 22 1945
BUREAU
RECEIVED
OCT 22
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09954

★ Reg. Diat. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs. 6 mo. 6 da.

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 12 yrs. 6 mo. 6 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2613 Reisterstown Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Clara Kramer Grossman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife Jacob Grossman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 18, 1888

8. AGE:

Years	Months	Days	If less than one day
57	7	1	..... hrs. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual occupation none

11. Industry or business none

FATHER 12. Name Jacob Kramer

13. Birthplace Russia

MOTHER 14. Maiden name Yedda Hoover

15. Birthplace Russia

16. Informant Hospital Records

Address Sykesville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 21, 1945 (month) (day) (year)

Cemetery or crematory United Hebrew Cemetery

Location Washington Blvd.

18. Funeral director Jack Lewis, Inc.

Address 210 Eutaw Place

19. Oct 19 1945 C. Harry Weed

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1945, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 1933, to Oct 19 1945

and that I last saw her alive on Oct. 18 1945

Immediate cause of death	DURATION
Lobar Pneumonia	2 da.
Due to	
Due to	
Other conditions Schizophrenia - Paranoid Type (Include pregnancy within 3 months of death)	14 yrs.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jo. Maud M. Rea M. D. or other

Address Sykesville Md Date signed 10-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

09955

★ Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 802 W. Mulberry St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOSEPH FREDERICK HALL

3.(b) Social Security Number: 215-16-6408

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 2, 1902

8. AGE: Years	Months	Days	If less than one day
43	9	16	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Huckster
11. Industry or business

FATHER
12. Name: Joseph Hall
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Martha Giles
15. Birthplace: Baltimore, Md.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof October 23 1945 (month) (day) (year)
Cemetery or crematory: Mt Auburn Cemetery
Location: Westport Md
18. Funeral director: Mrs Kate R. Williams
Address: 322 n Schroeder St.

19. 10/18 (Date rec'd by registrar) 19 45 Albert R. [illegible] Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18, 19 45 at 5.40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct., 15, 19 45 to Oct., 15, 19 45 and that I last saw him alive on October 18, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1942
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M. D. M. D. or other
Address: Henryton, Md. Date signed 10/18.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09956

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Md. (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 2 mos., 27 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: No definite, fixed address
(If rural, give LOCATION)
2.(a) If veteran, name war: /

3.(a) FULL NAME: William Hauser

3.(b) Social Security Number: #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband~~ or wife: Unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 13, 1886

8. AGE: Years	Months	Days	If less than one day
59	7	1	hrs. min.

9. Birthplace: Blount County, Tenn. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: James C. Hauser
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mary Jane McMurray (or Allison)
15. Birthplace: Unknown

16. Informant: Springfield Hospital Record
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 19 1945 (month) (day) (year)
Cemetery or crematory: Springfield Hosp. Cem.
Location: Sykesville, Md.
18. Funeral director: C. Harry Weer
Address: Sykesville, Md.
19. Oct 19 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14, 1945, at 8:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17, 1945, to Oct. 14 1945
and that I last saw him alive on October 14, 1945

Immediate cause of death	DURATION
Cerebral Haemorrhage	4 days
Due to: Cerebral and general Arteriosclerosis- prior to	7/17/43
Due to:	
Other conditions: Psychosis with Cerebral Arteriosclerosis- prior to	7/17/43

(Incinde pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M. D.
M. D. or other
Address: Sykesville, Md. Date signed: 10-14-45.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09957

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 3 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis San.
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 327 W. Preston. St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
GLADYS HOLMES

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	COLORED	WIDOWED

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1905

8. AGE:	Years	Months	Days	If less than one day
	39	11	9	hrs. min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business

FATHER
12. Name James Holmes
13. Birthplace Caroline Co., Va.

MOTHER
14. Maiden name Mary Bankhead
15. Birthplace Stafford Co., Va.

16. Informant Reuban Hoffman, M.D.
Address Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/24/45 (month) (day) (year)
Cemetery or crematory Mt. Zion.
Location Balto. Md.
18. Funeral director H. Halstead
Address 918 Druid Hill.

19. Oct. 20 1945 (Date rec'd by registrar) Albert R. Smallwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20, 1945 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 17 1945 to Oct. 20 1945 and that I last saw her alive on Oct 20 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.
M. D. or other
Address Henryton, Md. Date signed 10/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09958

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll Co.

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs 2 mo 16 da

Hospital, institution, or street address where death occurred: Springfield State Hosp.

How long in hospital or institution? 9 yrs 2 mo 16 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 920 N Bradford. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Alfred Horak.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M.

6.(b) Name of husband or wife: F

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 20 th 1906

8. AGE: Years: 39 | Months: 2 | Days: 25 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: unemployed

11. Industry or business:

MOTHER FATHER

12. Name: Alfred Horak

13. Birthplace: Maryland

MOTHER

14. Maiden name: Stella Krousek

15. Birthplace: Czechoslovakia

16. Informant: Mrs Stella Horak

Address: 920 N Bradford St Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/20/45 (month) (day) (year)

Cemetery or crematory: Oak Hill

Location: Horner's Lane

18. Funeral director: Charles E. Schimunek

Address: 2601-03 E. Madison Street

19. Oct. 20 1945 (Date rec'd by registrar) A. W. Hefrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 17th 1945 at 1-45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31st 1936 to Oct 17 1945 and that I last saw h[illegible] alive on Oct 17th 1945

Immediate cause of death	DURATION
Lobar Pneumonia	4 da
Due to	
Due to Epilepsy	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. H. Gaston M.D. M. D. or other

Address: Sykesville Md. Date signed: 10/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09959

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1513 North Rose Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Frederick Huber

3.(b) Social Security Number: 218-07-5092B

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Dietz
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 28, 1868

8. AGE: Years	Months	Days	If less than one day
77	3	19	hrs. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Hauler in brewery
11. Industry or business: Brewery

FATHER
12. Name: Frederick Huber
13. Birthplace: Germany

MOTHER
14. Maiden name: Margaret Wimlinger
15. Birthplace: Germany

16. Informant: Records of Springfield State Hospital, Sykesville, Md.
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-20-45 (month) (day) (year)
Cemetery or crematory: Holy Redeemer Cem.
Location: Belair Road
18. Funeral director: John C. Miller Inc.
Address: 2465 E. Oliver St.
19. Oct 18 19 45 (Date rec'd by registrar) A. W. Redpath Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17 19 45, at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10 19 45, to October 17 19 45
and that I last saw him alive on October 17 19 45

Immediate cause of death	DURATION
Bronchopneumonia	6 days
Due to:	
Due to:	
Other conditions: Psychosis with Cerebral Arteriosclerosis	?

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Arnold F. Eichert, M.D. M. D. or other
Address: Spring. Hosp. Sykesville, Md. Date signed: 10-17-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (110-C)

CERTIFICATE OF DEATH

09960

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Somerset
City or town: Upper Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: EVELYN VAUGHN JOHNSON

3.(b) Social Security Number: 219-05-9893

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Samuel Johnson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 3, 1892

8. AGE: Years	Months	Days	If less than one day
53	6	9	..... hrs. ..... min.

9. Birthplace: Cambridge, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Unknown

FATHER
12. Name: James Vaughn
13. Birthplace: Church Creek, Md.

MOTHER
14. Maiden name: Sarah Montgomery
15. Birthplace: Church Creek, Md.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: OCT 16 1945 (month) (day) (year)
Cemetery or crematory: Upper Hill
Location: Upper Hill Md
18. Funeral director: Chas H Ward
Address: Marriottsville Md

19. 10/12 (Date rec'd by registrar) 19 45 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12, 1945, at 6.00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 3, 1945, to Oct. 12, 1945 and that I last saw her alive on October 12, 1945

Immediate cause of death	DURATION
Cardiac Failure	
Due to: Etiology undetermined	Sept. 1945
Due to:	
Other conditions: Plural Effusion Etiology undetermined	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 10/12/45

CHANGE OF items 7 &8:
Dr. Jones' letter, Supt.
Springfield Hosp., filmed 10-31-45
G99 - L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

69961

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mo. 29 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2mo. 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Unknown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Unknown
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William James Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Mrs. Mattie Johnson

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): NOV. 11, 1875 Unknown 11/11/1876

8. AGE: Years	Months	Days	If less than one day
69 (67)	7 11	? 19	..... hrs. ..... min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Nightwatchman

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Records of Springfield State Hospital, Sykesville, Md.
Address: Springfield State Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-29-45 (month) (day) (year)
Cemetery or crematory: Reisters Cem.
Location: Westminster Md
18. Funeral director: L. F. Kuck
Address: 5305 Harford Rd

19. Oct 26 1945 (Date rec'd by registrar) C. Harry Ward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26 1945 at 11:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 1945, to October 26 1945 and that I last saw h... alive on October 26 1945

	DURATION
Immediate cause of death	
Chronic Myocarditis	
Due to: Generalized Arteriosclerosis	
Due to:	
Other conditions: Bronchitis & Cerebral Arteriosclerosis	10 mos.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date at:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eidart, M.D.
M. D. or other
Address: S. H. Hosp. Sykesville, Md. Date signed 10-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

69962

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County
City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 300 N. Exeter Street (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME HENRY C. JUSTIS

3. (b) Social Security Number

4. Sex: male
5. Color or race: colored
6.(a) Single, married, widowed, or divorced: single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Month ? date ?, 1913

8. AGE:	Years	Months	Days	If less than one day
	32	?"	?	... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Reuben Hoffman, M. D.
Address Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof oct 21-45 (month) (day) (year)
Cemetery or crematory Durham
Location N. C.
18. Funeral director Elroy O. Wilson
Address 1000 Brantley ave

19. 10/18 19 45 Albert R. Swankham (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 19 45 at 6.10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10, 19 45 to Oct., 18, 19 45 and that I last saw him alive on October 18, 19 45

Immediate cause of death Pulmonary Tuberculosis — DURATION Aug. 1945

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman M.D. M. D. or other
Address Henryton, Md. Date signed 10/18/45

09963

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: County Carroll. City or town Sykesville, Md. (Rural). (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? 8 yrs., 11 mos., 18 days. Hospital, Institution, or street address where death occurred: Springfield State Hospital. How long in hospital or institution? 8 yrs., 11 mos., 18 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State Maryland. County ..... City or town Baltimore. (If outside city or town limits, write RURAL and give nearest town) Street No. Unknown. (If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Louis Karasky.

3. (b) Social Security Number #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White	Unknown.

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1879 — exact date unknown.

8. AGE: Years	Months	Days	If less than one day
66.	Unk.	Unk.	..... hrs. ..... min.

9. Birthplace Russia. (Town, county, and state)

10. Usual occupation Tailor.

11. Industry or business

FATHER 12. Name Unknown.

13. Birthplace Unknown.

MOTHER 14. Maiden name Unknown.

15. Birthplace Unknown.

16. Informant Springfield Hospital Record.

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-24-45 (month) (day) (year)

Cemetery or crematory Hebrew Mt. Carmel

Location Balto. Md.

18. Funeral director Jack Heiss Inc

Address 1439 E. Balto. St

19. Oct. 23 1945 (Date rec'd by registrar) C. Harry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1945, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 17, 1936, to Oct. 22, 1945. and that I last saw him alive on Oct. 22, 1945.

Immediate cause of death General Paralysis of the Insane. prior to — DURATION 11-4-'36

Due to Syphilis.

Due to .....

Other conditions Psychosis with General Paresis — prior to 11-4-36.

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Harry F. Baer, M.D., M. D. or other

Address Sykesville, Md. Date signed 10-22-45.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09964

★ Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 2 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 651 W. Fairmount Ave., (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MARY KENNEDY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Widow

6.(b) Name of husband or wife:
B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept., 11, 1897

8. AGE: Years	Months	Days	If less than one day
48	1	8	hrs. min.

9. Birthplace: Prosperity, N. C. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Mose Brown
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

18. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-22-45 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location:
18. Funeral director: Adolphus Saltzman
Address: 918 Druid Hill Ave.

19. 10/19 (Date rec'd by registrar) 19 45 Albert R. Swarthout Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 19, 1945, at 11.15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept., 17, 1945, to Oct. 19 1945 and that I last saw her alive on October 19, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M. D. M. D. or other
Address: Henryton, Md. Date signed 10/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 099676

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 128½ Penn. Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Cook Knight

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Cora Reitzer

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 22 1857

8. AGE:

Years	Months	Days	If less than one day
88	4	27	..... hrs. ..... min.

9. Birthplace Frederick, Md.

(Town, county, and state)

10. Usual occupation Cooker

11. Industry or business

FATHER 12. Name Samuel Knight

13. Birthplace Frederick, Md.

MOTHER 14. Maiden name Mary Duble

15. Birthplace Frederick, Md.

16. Informant Mrs Jesse Berman

Address 128½

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 23. 1945 (month) (day) (year)

Cemetery or crematory Prudence Cemetery

Location Westminster, Md.

18. Funeral director H Bankard & Son

Address Westminster, Md

19. 10 22 1945 L K Woodward

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19. 1945 at 12 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 18th 1945 to Oct 19. 1945

and that I last saw h[illegible] alive on Oct 19th 1945

Immediate cause of death	DURATION
Acute Cardiac Dilatation -	1 hr
Due to Chronic Myocarditis	3 yrs
Due to Chronic arteriosclerosis	8 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Edwin R Fouty M.D. M. D. or other

Address Westminster Md Date signed 10.22.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (41)

09966

CERTIFICATE OF DEATH

Reg. Diat. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles B. Knox

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Nellie Copenhaver Knox

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1879

8. AGE: Years	Months	Days	If less than one day
65	10	21	hrs. min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden name Mary J. Knox

15. Birthplace Md.

16. Informant Mrs. Nellie Knox

Address Taneytown, Md.

17. Burial Date thereof Oct. 26, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Joseph's

Location Taneytown, Md.

18. Funeral director C. O. FUSS & SON

Address Taneytown, Md.

19. Oct 26, 1945 Ethel M Mehring
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22nd 1945, at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 21st 1945, to Oct 22nd 1945 and that I last saw him alive on Oct 21st 1945

	DURATION
Immediate cause of death Organic Valvular heart disease Pathog of lung Valve -	1 mo.
Due to Arterio Sclerosis -	2 yr
Due to	
Other conditions Diabetes	1 year

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. M. Benner M D
M. D. or other

Address Taneytown Md Date signed 10/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

09967

★ Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 8 mo. 20 da

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 yrs. 8 mo. 20 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3806 Dorchester Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Annie R. Laupheimer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife Elmer E. Laupheimer

6.(c) If alive, give age Unkn years

7. Birth date of deceased (mo., day, yr.) October 20, 1875

8. AGE: Years	Months	Days	If less than one day
70	0	2	hrs. min.

9. Birthplace Windsboro, South Carolina (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name Gustav Rosenheimer

13. Birthplace Germany

MOTHER 14. Maiden name Betsy Frank

15. Birthplace Maryland

16. Informant Hospital Records

Address Sykesville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/24/45 (month) (day) (year)

Cemetery or crematory Hebrew Friendship

Location Phila Rd.

18. Funeral director David Tomdheim & Son

Address 1902 Eutaw Place

19. Oct. 23 1945 C. Gladys Weed

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1945 at 10.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 1942, to October 22 1945

and that I last saw her alive on October 22 1945

Immediate cause of death	DURATION
General Arteriosclerosis	4 yrs.
Due to	
Due to	
Other conditions Psychosis with Cerebral Arteriosclerosis	4 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hans M. Rees M.D. M. D. or other

Address Sykesville Md. Date signed 10-22-45


OCT 24 1945
BUREAU V.S.
OCT 24 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

09968

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 6 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Frederick
City or town Adamstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
FRANCES VICTORIA LEEKS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 4, 1931

8. AGE: Years	Months	Days	If less than one day
13	10	9	hrs. min.

9. Birthplace Frederick, Md.
(Town, county, and state)
10. Usual occupation Scholar
11. Industry or business at school
FATHER 12. Name William B. Leeks
13. Birthplace Poolsville, Md.
MOTHER 14. Maiden name Virginia Adams
15. Birthplace Poolsville, Md.
16. Informant Reuben Hoffman, M. D.
Address Henryton, Md.
17. Burial, cremation, or removal. Which?) Burial Date thereof Oct 17 45 (month) (day) (year)
Cemetery or crematory Dela Frederick Cem'l
Location
18. Funeral director Robert L. Snowden
Address Rockville Md
19. 10/13 19 45 (Date rec'd by registrar) Albert R. Brandhorst Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13, 19 45, at 3.10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 7, 19 45, to Oct., 13, 19 45
and that I last saw her alive on October 13, 19 45

Immediate cause of death Pulmonary Tuberculosis — DURATION May 25, 1945
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman M.D.
M. D. or other
Address Henryton, Md. Date signed 10/13/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

09969

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1306 Riggs Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ELLA MARY LEWIS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Pete Lewis
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 22, 1918

8. AGE: Years	Months	Days	If less than one day
-27	4	18	hrs. min.

9. Birthplace: Woodland, N. C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: at home

FATHER
12. Name: John Henry
13. Birthplace: Unknown

MOTHER
14. Maiden name: Daisy James
15. Birthplace: North Carolina

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 13-45 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore City.
18. Funeral director: Geo. G. Kelson
Address: 1303 Presstman St.
19. 10/10 1945 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10, 1945, at 2.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 26, 1945, to Oct. 10, 1945 and that I last saw her alive on October 10, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other
Address: Henryton, Md. Date signed 10/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

09970

Reg. Dist. No. 78

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural--Gypsy Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural--Gypsy Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. Westminster

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: ERBA BAILE LINDSAY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 18, 1882

8. AGE: Years	Months	Days	If less than one day
63	0	9	hrs. min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Joseph Lindsay

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Clara Baile

MOTHER 15. Birthplace: Maryland

18. Informant: Miss Bertie L. Lindsay

Address: Westminster, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 10-30-45 (month) (day) (year)

Cemetery ~~or crematory~~: Pipe Creek Methodist

Location: Wakefield. Carroll Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. 10-29-1945 (Date rec'd by registrar) E. M. Fauver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 27, 1945 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar 8. 1945, to Oct 27. 1945

and that I last saw him alive on Oct 27. 1945

Immediate cause of death	DURATION
Acute Cardiac dilatation	6 hrs
Due to: Bronchial Pneumonia	24 hrs
Due to: arterio. sclerosis	5 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Chas R Foutz MD M. D. or other

Address: Westminster Date signed: 10-29-45


RECEIVED
OCT 30 1943

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09971

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Popes Creek
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: ANNIE LIVERS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept., 13, 1927

8. AGE:	Years	Months	Days	If less than one day
	18	1	17	hrs. min.

9. Birthplace: Wicomico, Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Mud Livers
13. Birthplace: Wicomico, Md.

MOTHER
14. Maiden name: Loretta Hicks
15. Birthplace: Wicomico, Md.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11 / 1 / 45 (month) (day) (year)
Cemetery or crematory
Location: New Port, Md
18. Funeral director: Hunt & Ryon
Address: Waldorf, Md.

19. 10/30 (Date rec'd by registrar) 19 45 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30, 19 45, at 6.15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19, 19 45 to Oct., 30, 19 45 and that I last saw her alive on October 30, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March
	June 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed 10/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 1 day
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1844 Pennsylvania Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: JOSEPH MILBERT MARSHALL

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 4, 1888

8. AGE: Years	Months	Days	If less than one day
57	9	13	hrs. min.

9. Birthplace: White Plains, Md.
(Town, county, and state)
10. Usual occupation: Farm Laborer
11. Industry or business: On Farm

FATHER
12. Name: Ben Marshall
13. Birthplace: Bryantown, Md

MOTHER
14. Maiden name: Mollie Hawkins
15. Birthplace: Bryantown, Md.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/20/45 (month) (day) (year)
Cemetery or crematory
Location: Waldorf, Md
18. Funeral director: Dunnick & Ryon
Address: Waldorf Md

19. 10/17 (Date rec'd by registrar) 19 45 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17, 1945 at 9.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16, 1945 to Oct. 17, 1945 and that I last saw him alive on October 17, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other
Address: Henryton, Md. Date signed: 10/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09973

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 19 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Country--Bahamas County:
City or town: Nassau.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: STANLEY McBRIDE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Unknown, 1920

8. AGE:	Years	Months	Days	If less than one day
	25	?	?	hrs. min.

9. Birthplace: Bahamas, British West Indies
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 6, 1945 (month) (day) (year)
Cemetery or crematory: Salisbury
Location: Salisbury, Md.
18. Funeral director: James H. Stewart
Address: Salisbury, Md.

19. 10/2 (Date rec'd by registrar) 1945 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 2, 1945, at 9.15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 13, 1945, to Oct., 2, 1945
and that I last saw h im alive on October 2, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug., 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other
Address: Henryton, Md. Date signed: 10/2/45


RECEIVED
OCT 8 1945
BUREAU P.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09974

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 14 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 months, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2003 Maryland Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Jean V. McCray

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Vance McCray
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 22, 1880

8. AGE:	Years	Months	Days	If less than one day
	64	11	20	hrs. min.

9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: ---

FATHER
12. Name: Taylor Brohard
13. Birthplace: ?

MOTHER
14. Maiden name: Nancy Marple
15. Birthplace: ?

18. Informant: Records of Springfield State Hospital, Sykesville, Md.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 15, 1945 (month) (day) (year)
Cemetery or crematory: Springfield Cemetery
Location: Sykesville, Md.
18. Funeral director: C. Harry Klee
Address: Sykesville, Md.

19. Oct 15 1945 (Date rec'd by registrar) C. Harry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12, 1945, at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 28, 1945, to October 12, 1945
and that I last saw h[illegible] alive on October 12, 1945

Immediate cause of death	DURATION
Bronchopneumonia	2 hrs.
Due to:	
Due to:	
Other conditions: Psychosis - syphilitic meningo-encephalitis	?

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.
M. D. or other
Address: St. Hosp. Sykesville, Md. Date signed: 10-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

09975

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 month, 19 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1112 Fremont Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
TONY MYERS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

B.(b) Name of husband or wife
B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1943

8. AGE: Years	Months	Days	If less than one day
2	4	17	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Harry Myers
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden name Katherine Valentine
15. Birthplace Baltimore, Md.

16. Informant Reuben Hoffman, M. D.
Address Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-20-45 (month) (day) (year)
Cemetery or crematory Mt Calvary
Location A.A. Co., Md.
18. Funeral director Adolphus Halstead
Address 918 Druid Hill, Ave.

19. 10/18 (Date rec'd by registrar) 19 45 Albert R. Trunkhaus Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 19 45 at 7.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29, 19 45, to Oct., 18, 19 45
and that I last saw him alive on October 18, 19 45

	DURATION
Immediate cause of death Tuberculous Meningitis	Oct. 4, 1945
Due to Primary Tuberculosis	Jan. 1945
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Address Henryton, Md. Date signed 10/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09976

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 5 mos. 28 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Dundalk.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 204 Avondale Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: FREDERICK NEWTON, JR.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 30, 1925

8. AGE: Years	Months	Days	If less than one day
20	4	9	hrs. min.

9. Birthplace: Red Springs, N. C.
(Town, county, and state)

10. Usual occupation: Welder

11. Industry or business:

FATHER
12. Name: Frederick Newton, Sr.
13. Birthplace: Red Springs, N. C.

MOTHER
14. Maiden name: Barbara McCoy
15. Birthplace: Red Springs, N. C.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-13-45 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial Pk.
Location: Arbutus, Md.

18. Funeral director: Chas. R. Law
Address: 802 Madison Ave.

19. 10/9 (Date rec'd by registrar) 19 45 Albert R. Smallwood Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9, 19 45 at 2.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11, 19 44, to Oct. 9, 19 45
and that I last saw him alive on October 9, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept., 1943
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other
Address: Henryton, Md. Date signed 10/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

69977

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 22 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 305 Second St.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: PAULINE THELMA PRICE

3.(b) Social Security Number: 219-05-3624

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 22, 1911

8. AGE: Years	Months	Days	If less than one day
34	8	13	hrs. min.

9. Birthplace: Dames Quarters, Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Unknown
FATHER 12. Name: Archie Lee
13. Birthplace: Dames Quarters, Md.
MOTHER 14. Maiden name: Mary Wigfall
15. Birthplace: Dames Quarters, Md.
16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/9/45 (month) (day) (year)
Cemetery or crematory: Dames Quarters Md
Location:
18. Funeral director: James R. Ward
Address: Salisbury Md
19. 10/5 (Date rec'd by registrar) 19 45 Albert R. Smith Registrar
De uty Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 5, 1945 at 10.00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1945 to Oct. 5, 1945 and that I last saw him alive on October 5, 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1945
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other
Address: Henryton, Md. Date signed: 10/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

09978

★Reg. Dist. No. 24

1. PLACE OF DEATH:
County Carroll
City or town Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo. 5 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 1 month, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1600 N. Hilton St.
(If rural, give LOCATION)
2.(a) If veteran, ocme war

3.(a) FULL NAME William Purcell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1915

8. AGE: Years	Months	Days	If less than one day
30	2	28	hrs. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Stewart Purcell
13. Birthplace Ireland

MOTHER
14. Maiden name Julia Eichelberger
15. Birthplace Baltimore, Md.

16. Informant Records of Springfield State
Address Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 22, 1945 (month) (day) (year)
Cemetery or crematory London Park Cem.
Location Balto. Md.
18. Funeral director John O. Mitchell & Sons
Address 1900 Eutaw Place

19. Oct 19 1945 (Date rec'd by registrar) C. Harry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1945 at 1.59 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 14 1945 to Oct 19 1945 and that I last saw him alive on Oct. 19 1945

Immediate cause of death	DURATION
Bronchopneumonia	24 hrs.
Due to Aspiration	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Ronald H. Eichelberger M.D.
M. D. or other
Address S.H. Hosp. Sykesville, Md. Date signed 10-19-45

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09979

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 1 day
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Calvert
City or town Lsland Creek
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
JAMES ALFRED REYNOLDS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife Eliza Reynolds
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec., 24, 1878

8. AGE: Years	Months	Days	If less than one day
66	9	11	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business on farm
FATHER 12. Name Unknown
13. Birthplace Unknown
MOTHER 14. Maiden name Annie Coates
15. Birthplace Maryland
16. Informant Reuben Hoffman, M. D.
Address Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 8 45 (month) (day) (year)
Cemetery or crematory Brooks Chapel
Location Calvert Co
18. Funeral director P. E. Sowell
Address Prince Frederick Md
19. 10/5 19 45 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1945, at 6.30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 4, 45 to Oct., 5 1945
and that I last saw him alive on October 5, 1945

Immediate cause of death: Carcinoma of lung — DURATION: Jan. 1945
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M. D. M. D. or other
Address Henryton, Md. Date signed 10/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1642)

CERTIFICATE OF DEATH

69980

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long to above place of death? 1 year, 5 months, 21 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 1 year, 5 months, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 205 Cedar Avenue
(If rural, give LOCATION)

(c) If veteran, name war

3. (a) FULL NAME
Jean Martha Richter

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Kenneth S. Richter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 7, 1922

8. AGE: Years	Months	Days	If less than one day
23	4	11	..... hrs. ..... min.

8. Birthplace: Sank Center, Minnesota
(Town, county, and state)

10. Usual occupation: Salesgirl

11. Industry or business: ----

FATHER
12. Name: William Hardy
13. Birthplace: Unknown

MOTHER
14. Maiden name: Margy Hodson
15. Birthplace: North Dakota (?)

16. Informant: Records of Springfield State
Address: Hospital, Sykesville, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Oct 22, 1945 (month) (day) (year)

Cemetery or crematory: Geo. Washington Memorial

Location: Mt. Wash. D.C.

18. Funeral director: W.W. Chambers Co.

Address: Riverdale, Md.

19. Oct 19 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18 1945, 5:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Surgical Shock	
Due to: Fracture left femur and Pelvis	
Due to	
Other conditions: Open riding fracture middle third left femur	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: Oct. 14-1945

Where did injury occur? Eldersburg (City or town) Carroll (County) Md. (State)

Injured at home, farm, industry, public place (where): Public Highway

Means of injury: Three bullet wounds in front of automobile Injured at work? No

23. SIGNATURE: James T. Shard, Deputy Medical Examiner M. D. or other

Address: Westminster, Md. Date signed: Oct. 18-1945

Synonym 128

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87d)

CERTIFICATE OF DEATH

09981

★ Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll.
City or town: Sykesville, Md. (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mos., 20 days.
Hospital, institution, or street address where death occurred:
Springfield State Hospital.
How long in hospital or institution? 8 mos., 20 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Allegany.
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 325 Arch.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Harvey Le. Riggleman.

3. (b) Social Security Number: #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White	Separated.

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 7, 1895

8. AGE: Years	Months	Days	If less than one day
50.	2.	5	hrs. min.

9. Birthplace: Winchester, Virginia.
(Town, county, and state)

10. Usual occupation: Carpenter.

11. Industry or business:

FATHER
12. Name: David Riggleman.
13. Birthplace: West Virginia.

MOTHER
14. Maiden name: Katie Eversole.
15. Birthplace: Virginia.

16. Informant: Springfield Hospital Record.
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 16, 1945 (month) (day) (year)
Cemetery or crematory: Cumberland
Location: Cumberland, Md.

18. Funeral director: Hafer Funeral Home
Address: Cumberland, Md.

19. Oct. 13, 1945 (Date rec'd by registrar) C. Harry Eberly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12, 1945 at 8:00 p.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 22, 1945 to Oct. 12, 1945
and that I last saw h[im] alive on October 12, 1945.

Immediate cause of death	DURATION
Organic changes in the Nervous System (Multiple Sclerosis) prior to	1-22-45
Due to:	
Due to:	
Other conditions: Psychosis with Multiple Sclerosis - prior to (Include pregnancy within 3 months of death)	1-22-45

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry J. Baer, M.D.
M. D. or other
Address: Sykesville, Md. Date signed 10/12/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09982 — Reg. Dist. No. 7Y

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 1 mo 18 da

Hospital, institution, or street address where death occurred: Spring Field State Hospital

How long in hospital or institution? 1 yr 1 mo 18 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war:

3. (a) FULL NAME: Evelina Rosina Riley

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	married

6. (b) Name of husband or wife:

6. (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 17 - 1866

8. AGE: Years: 79 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation:

11. Industry or business: not any

FATHER — 12. Name:

FATHER — 13. Birthplace: unknown

MOTHER — 14. Maiden name:

MOTHER — 15. Birthplace: unknown

16. Informant: Robert Riley

Address: 2693 Eulaw St Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-20-45 (month) (day) (year)

Cemetery or crematory: Western

Location: Baltimore

18. Funeral director: Frederick A Cole

Address: 1308 W. Lombard St.

19. 10/19 19 45 Ste Gabriel (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 18 19 45 at 12:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 23 19 43, to Oct 18 19 45 and that I last saw h es alive on Oct 18 19 45

Immediate cause of death	DURATION
Bronchial Pneumonia	1 da
Due to:	
Due to: Congestive Heart Failure	1 mo
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. H. Gaston M.D. M. D. or other

Address: Sykesville Date signed: 10/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09983

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 10 Mos. 26 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 404 Ogston St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Jacob Daniel Robinson

3.(b) Social Security Number: 241-14-8205

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	Married

6.(b) Name of husband or wife: Pauline Robinson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 1, 1913

8. AGE: Years	Months	Days	If less than one day
32	3.	7	hrs. min.

9. Birthplace: Shelby, N.C.
(Town, county, and state)
10. Usual occupation: laborer
11. Industry or business

FATHER
12. Name: Jacob Robinson
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Mary Jimison
15. Birthplace: South Carolina

16. Informant: Reuban Hoffman, M.D.
Address: Henryton, Md,

17. Buried (Burial, cremation, or removal. Which?) Date thereof Oct. 11-45 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Balto Co, Md.
18. Funeral director: Elroy C. Wilson
Address: 1000 Brantley ave

19. 10/8 (Date rec'd by registrar) 45 Albert R. Smallwood Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 8, 1945, at 1-10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 12, 1943, to Oct. 8, 1945 and that I last saw him alive on October 8, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug., 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 10/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

09984

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 month, 18 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1804 Eagle Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: RAYMOND ROBINSON

3.(b) Social Security Number: 218-22-9041

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 4, 1930

8. AGE: Years	Months	Days	If less than one day
15	7	16	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: James Moore
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anna Robinson
15. Birthplace: Virginia

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/25/45 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Anne Arundel County
18. Funeral director: Chas. L. Forbus
Address: 512 N. Carrollton Ave.

19. 10/20 19 45 (Date rec'd by registrar) Depoty Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 20, 19 45 at 10.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2, 19 45, to Oct., 20, 19 45 and that I last saw him alive on October 20, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M. D.
M. D. or other
Address: Henryton, Md Date signed: 10/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (79-1)

CERTIFICATE OF DEATH

★ 09985

Reg. Diat. No. 77

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Entire Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Hampstead
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Emmeline Letha Ruby

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow

6.(b) Name of husband or wife: Israel Ruby
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Dec. 16 - 1855

8. AGE:

Years	Months	Days	If less than one day
89	10	12	— hrs. — min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
12. Name of father: Adam Letto
13. Birthplace of father: Maryland
14. Maiden name of mother: Miss Fisher
15. Birthplace of mother: Unknown
16. Informant: Elmer Ruby
Address: Hampstead Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 31/45 (month) (day) (year)
Cemetery or crematory: Hampstead
Location: Hampstead Md
18. Funeral director: Edw C Fuhrton
Address: Hampstead Md
19. Oct. 29 1945 (Date rec'd by registrar) John S. Hughes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 28, 1945, at 8.05 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 23, 1945 to Oct. 28 1945 and that I last saw h.. alive on Tuesday Oct 23 1945

Immediate cause of death: Cerebral Hemorrhage 4 hr

	DURATION
Due to: Hypertension, Cerebro-Vascular Degeneration	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Cordelia E. Rush M.D.
M. D. or other
Address: Hampstead Md. Date signed: 10-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10498

Reg. Diat. No. 81

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge
(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For nowborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Broadway
(If rural, give LOCATION)

2.(a) If veteran, name war: Home

3.(a) FULL NAME: Silas Deane Senseney

3.(b) Social Security Number: 212-14-6178

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Anna Senseney

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 6 - 1855

8. AGE: Years: 90 | Months: 2 | Days: 26 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll County Maryland
(Town, county, and state)

10. Usual occupation: Merchant - Bank President

11. Industry or business: Retired

FATHER
12. Name: A. Hanson Senseney
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lavinia Engler
15. Birthplace: Maryland

16. Informant: Miss Marie Senseney
Address: Union Bridge Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 4 - 1945 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cemetery

Location: Uniontown - New Windsor Road

18. Funeral director: D. D. Hartle & Son

Address: Union Bridge & New Windsor Md.

19. Oct 4 1945 (Date rec'd by registrar) E. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 2 1945, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10/2 1945 to 10/2 1945 and that I last saw him alive on 10/2 1945

	DURATION
Immediate cause of death: Cardiac failure, acute;	2-3d
Due to: Interstitial sclerotic cardio-vas. disease,	
Due to:	
Other conditions: Hyp. arteriosclerosis; senility	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: E. L. Seigman M.D. or other

Address: Union Bridge, Md. Date signed: 10/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09986

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months, 23 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Fruitland (If outside city or town limits, write RURAL and give nearest town)

Street No.: Clyde Avenue (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: SAMUEL JAMES SORDEN

3.(b) Social Security Number: 207-12-8842

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Lola Sorden

6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): Oct., 10, 1910

8. AGE:

Years	Months	Days	If less than one day
34	11	25	..... hrs. ..... min.

9. Birthplace: Fruitland, Md. (Town, county, and state)

10. Usual occupation: Service Station Worker

11. Industry or business: Unknown

FATHER

12. Name: Emory Sorden

13. Birthplace: Harrington, Delaware

MOTHER

14. Maiden name: Ceacy Gale

15. Birthplace: Fruitland, Md.

16. Informant: Reuben Hoffman, M. D.

Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-9-45 (month) (day) (year)

Cemetery or crematory: Mt Calvary

Location: Fruitland, Md.

18. Funeral director: James G. Stewart

Address: Salisbury, Md.

19. 10/5 (Date rec'd by registrar) 1945 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct., 5, 1945 at 10.00 M P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12 1945, to Oct., 5, 1945 and that I last saw him alive on October 5, 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Jan. 1944

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other

Address: Henryton, Md. Date signed 10/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

09987

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 2 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Santorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Elkridge, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Race Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ELVA SPRIGGS

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 11, 1917

8. AGE: Years	Months	Days	If less than one day
28	7	9.	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Maid
11. Industry or business: Unknown

FATHER
12. Name: Charles Spriggs
13. Birthplace: Unknown

MOTHER
14. Maiden name: Frances ?
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 24/1945 (month) (day) (year)
Cemetery or crematory: Elkridge Md
Location: Elkridge Md.
18. Funeral director: Walter R. Williams
Address: 322 N. Charles St

19. 10/20 (Date rec'd by registrar) 19 45 Albert R. Swanson Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 20, 1945 at 7.00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 1945 to Oct., 20, 1945 and that I last saw her alive on Oct., 20, 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: July, 1945

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed 10/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

03388

1. PLACE OF DEATH (117a)

County Carroll Registration Dist. No. 7476

Village or City Westminster No. Carroll Co. Home St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Monte Gilbert Stevenson Howard Co

(a) Residence: No. West Friendship, Md. St., Ward.
(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) Sept 12, 1876

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	1	4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Laborer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Farm

10. Date deceased last worked at this occupation (month and year) — 11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) Carroll County (State or country) Md.

FATHER

13. NAME York —

14. BIRTHPLACE (city or town) York. (State or country)

MOTHER

15. MAIDEN NAME York. —

16. BIRTHPLACE (city or town) York. (State or country)

17. INFORMANT Mr. D. K. Strawbridge
(Address) West Friendship, Md.

18. BURIAL, CREMATION, OR REMOVAL
Place Burial Data Oct. 18, 1945

19. UNDERTAKER C. Harry Wenz
(Address) Sykesville, Md.

20. FILED Oct. 18, 1945 C. Harry Wenz
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH 10 (Month) 16 (Day) 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 7-4-1935 to 10-16-1945
I last saw him alive on 10-16-45, 19... ; daath is said to hava occurred on the date stated above, at ... m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Data of onset
Pernicious Anemia	1 yr
Other Contributory Causes of importance:	
Gastric ulcers	20 yr

Name of oparation ... Date of ...
What test confirmed diagnosis? ... Was thera an autopsy? ...

23. If daath was dua to extarnal causes (VIOLENCE) fill in also the following:
Accident, suicide, or homicide? X Date of injury ..., 19...
Whara did injury occur? ...
(Specify city or town, county and State)
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury X
Natura of Injury

24. Was diseasa or injury in any way relatad to occupation of deceased? No
If so, specify ...
(Signed) N. C. Stone Jr. M. D.
(Addrass) Westminster Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09989

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 20 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1103 E. Monument St.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MATTIE JANE SYKES

3.(b) Social Security Number: 216-20-2017

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

B.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 19, 1927

8. AGE: Years	Months	Days	If less than one day
18	3	25	hrs. min.

9. Birthplace: Raleigh, N. C. (Town, county, and state)
10. Usual occupation: Maid
11. Industry or business

FATHER
12. Name: Luther Sykes
13. Birthplace: Raleigh, N. C.

MOTHER
14. Maiden name: Izzetta Grant
15. Birthplace: Raleigh, N. C.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof oct 18-45 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: B. C. Co., Md.
18. Funeral director: Elroy O Wilson
Address: 1000 Brantley Ave

19. 10/14 (Date rec'd by registrar) 19 45 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14, 1945, at 11.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 26, 1945, to Oct., 14, 1945
and that I last saw her alive on October 14, 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Jan. 1945
Due to:
Due to:
Other conditions:
(Incinde pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other
Address: Henryton, Md. Date signed: 10/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P9990

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs. 3 mos. 1 day
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 10 yrs. 3 mos. 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: —
City or town: Baltimore - 29
(If outside city or town limits, write RURAL and give nearest town)
Street No. 117 So. Morley St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Howard Leonard Tucker

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Susie C. Tydings
6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): March 21, 1898

8. AGE: Years	Months	Days	If less than one day
47	6	20	....hrs. ....min.

9. Birthplace: Elkridge, Md. (Town, county, and state)
10. Usual occupation: Insurance salesman
11. Industry or business: Insurance Co.
FATHER 12. Name: Joseph M. Tucker
13. Birthplace: Maryland
MOTHER 14. Maiden name: Annie Liebt
15. Birthplace: Maryland
16. Informant: Hospital records
Address: Sykesville, Carroll County, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-15-45 (month) (day) (year)
Cemetery or crematory: Western
Location: Baltimore, Md.
18. Funeral director: George L. Schwab
Address: 2101 Frederick Avenue
19. Oct. 13 1945 (Date rec'd by registrar) A. N. Hedgick per A.E.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11 1945 at 7:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 1941, to Oct. 11 1945 and that I last saw him alive on Oct 11 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 mos.(?)
Due to	
Due to	
Other conditions: Dementia Praecox, Paranoid type	11 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? .... (City or town) .... (County) .... (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE: Arnold H. Sibert M.D. M. D. or other
Address: Union, Sykesville Md. Date signed: 10-11-45

09991

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 57 W. Green
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles Emory Walkling

3. (b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Jeannetta Magin
6.(c) If alive, give age 50 years
7. Birth date of deceased (mo., day, yr.) July 4 - 1894

8. AGE: Years	Months	Days	If less than one day
51	3	8	...hrs. ...min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual occupation Clerk: Trial Magistrate
11. Industry or business
FATHER 12. Name Henry F. Walkling
13. Birthplace Md.
MOTHER 14. Maiden name Emma J. Frey
15. Birthplace Ind.
18. Informant Jeannetta Magin Walkling
Address 57 W. Green St. Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 15-1945 (month) (day) (year)
Cemetery or crematory Druk park
Location Smallwood, Md.
18. Funeral director D. Bankard & Son
Address Westminster, Md.
18. 10/14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 1945 at 7:15 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1935, to October 12 1945
and that I last saw him alive on October 12 1945

Immediate cause of death	DURATION
Coronary Thrombosis & Cerebral Embolus	3 hrs.
Due to Hypertensive Cardio vascular Renal Disease	
Due to myocardial degeneration	10 yrs.
Other conditions Arterio Sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other
Address Westminster Md. Date signed 10/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

09992

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 265 E. Green

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Gertrude J. Warehime

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Frank C. Warehime

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) October 8 1876

8. AGE: Years	Months	Days	If less than one day
69	—	18	..... hrs. ..... min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Poole

13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden name Elizabeth Murray

15. Birthplace Carroll Co. Md.

16. Informant Frank C. Warehime

Address 265 E. Green St. Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 29-1945 (month) (day) (year)

Cemetery or crematory Calvary Methodist Cemetery

Location Gamber, Carroll Co. Md.

18. Funeral director H. Bankard & Son

Address Westminster, Md.

19. 10/28/45 (Date rec'd by registrar) H. Bankard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 19 45, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 19 45, to Oct 26 19 45

and that I last saw h. alive on Oct 26 19 45

Immediate cause of death	DURATION
Carcinoma of Colon	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Mead M. D. or ~~Coroner~~

Address Westminster Md Date signed Oct 26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 09993

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 2 years
Hospital, institution, or street address where death occurred:
Daneytown Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1 Mile out Daneytown Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Thomas Warren

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife: Susan Myers Warren
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 6. 1869

8. AGE: Years: 76 Months: 9 Days: 23 If less than one day: hrs. min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: retired

11. Industry or business

FATHER
12. Name: Elias Warren
13. Birthplace: Carroll Co. Md.

MOTHER
14. Maiden name: Elizabeth De Moss
15. Birthplace: Carroll Co. Md.

16. Informant: Marlin P. Warren
Address: South Center St. Westminster

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/31/45 (month) (day) (year)
Cemetery or crematory: Bridges Cemetery
Location: near Westminster, Md.

18. Funeral director: J. E. Myers Jr.
Address: Westminster, Md.

19. 10/25/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 29- 1945, at 5a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15- 1945, to Oct 29 1945
and that I last saw h... alive on Oct 28 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	10 days
Hypertension (due to)	
Due to: Hypertension (due to)	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. C. Fennell M.D.
M. D. or other
Address: Westminster Md. Date signed: 10-29-45

RECEIVED
OCT 31 1945
BUREAU V.M.